P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
November 17, 2020

Administrator
The Emeralds At St Paul Llc
420 Marshall Avenue
Saint Paul, MN 55102

REVISED LETTER

RE: CCN: 245295
Cycle Start Date: October 5, 2020

This letter revises and replaces the previous letter dated October 19, 2020 to properly reflect enhanced enforcement remedies for Infection Control deficiencies.

Dear Administrator:

On October 5, 2020, a survey was completed at your facility by the Minnesota Department(s) of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 17, 2020.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 17, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 17, 2020.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by December 17, 2020, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, The Emeralds At St Paul Llc will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 17, 2020. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.
However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Karen Aldinger, Unit Supervisor
Metro C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually

occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 5, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions

are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
October 19, 2020

Administrator
The Emeralds At St Paul LLC
420 Marshall Avenue
Saint Paul, MN 55102

RE: CCN: 245295
Cycle Start Date: October 5, 2020

Dear Administrator:

On October 5, 2020, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility’s Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" tag), i.e., the plan of correction should be directed to:

Karen Aldinger, Unit Supervisor
Metro C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by January 5, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by April 5, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118 Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Electronically delivered
October 19, 2020

Administrator
The Emeralds At St Paul Llc
420 Marshall Avenue
Saint Paul, MN 55102

Re: State Nursing Home Licensing Orders
Event ID: JM1511

Dear Administrator:

The above facility was surveyed on October 2, 2020 through October 5, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Karen Aldinger, Unit Supervisor
Metro C District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: karen.aldinger@state.mn.us
Office: (651) 201-3794 Mobile: (320) 249-2805

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility’s Governing Body.

Please feel free to call me with any questions.

Sincerely,

Douglas Larson, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program

Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4118   Fax: 651-215-9697
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00913	A. BUILDING: ______ B. WING ______	C 10/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT ST PAUL LLC	**420 MARSHALL AVENUE SAINT PAUL, MN 55102**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 10/2/20-10/5/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT ST PAUL LLC	**420 MARSHALL AVENUE SAINT PAUL, MN 55102**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5295195C. H5295193C, H5295194C, were not substantiated. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control.	21390		11/20/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00913	A. BUILDING: ___ B. WING ___	C 10/05/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21390	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate hand hygiene (wash hands with soap and water or alcohol based hand sanitizer use) and glove usage to prevent cross-contamination during cares for 1 of 2 residents (R4) who were observed during personal cares. Findings include: R4's quarterly Minimum Data Set (MDS) dated 7/1/20, indicated R4 was cognitively intact, required physical assistance with bed mobility, toileting and personal hygiene and was always incontinent of bowel and bladder. On 10/2/20, at 10:19 a.m., nursing assistant (NA)-A entered R4's room and opened the top drawer of R4's bedside table and pulled out a package of wipes and closed the drawer. NA-A put gloves on without performing hand hygiene. NA-A pulled R4's pants down and opened the brief tabs. NA-A used wipes and washed R4's perineal area. NA-A had R4 roll to the left using the grab bar. R4's incontinence brief was full of soft brown stool. NA-A wiped the stool off R4's buttocks and removed the brief. Without changing gloves, NA-A picked up a clean brief and placed it on the bed. Wearing the same gloves, opened the top drawer to the bed side table and removed a tube of barrier cream from the bed side table. Using the same gloves, used to clean stool from R4's buttocks, NA-A applied barrier cream to R4's buttocks then had R4 roll onto the clean brief and applied the barrier cream to her perineal area. NA-A had R4 roll back onto	21390	corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT ST PAUL LLC	**420 MARSHALL AVENUE SAINT PAUL, MN 55102**

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21390	Continued From page 3 the clean brief. Without changing gloves, NA-A pulled up R4's pants, pulled down shirt and then removed gloves. Without performing hand hygiene NA-A touched and returned the wipes and barrier cream into the drawers of the bedside table. NA-A took the bag of trash out of the can and exited the room. NA-A opened the door to the soiled utility room and threw the trash away, then washed her hands. NA-A stated this was how she normally did R4's cares. NA-A stated she had used sanitizer before entering R4's room. NA-A verified she did not change gloves when done wiping the stool from R4's bottom until after adjusting R4's clothes. NA-A verified not sanitizing hands until washing them in the soiled utility room. On 10/2/20, at 2:25 p.m. the director of nursing (DON) stated gloves were to be changed between dirty and clean tasks and hand hygiene was to be done prior to putting on or removing gloves, and after cares. The DON stated staff should have changed gloves after doing incontinence cares before adjusting clothing or reaching into a resident's dresser drawer. Facility provided Hand washing/Hand Hygiene Policy revised August 2019, indicated facility considered hand hygiene the primary means to prevent the spread of infections. The policy indicated hand hygiene was to be performed before donning and removing gloves and before moving from a contaminated body site to a clean body site during cares. Suggested Method of Correction: The DON (Director of Nursing) or designee could review	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE EMERALDS AT ST PAUL LLC	**420 MARSHALL AVENUE SAINT PAUL, MN 55102**

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21390	Continued From page 4 and/or revise policies, education/ training related to proper hand hygiene and incontinence care procedures. Then the DON or designee could educate staff and perform audits to ensure the policies are being followed. Time Period for Correction 21 (twenty-one) days.	21390		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide care in a manner that promoted dignity for 1 of 2 residents (R4) reviewed for privacy during cares. Findings include: R4's quarterly Minimum Data Set (MDS) dated 7/1/20, indicated R4 was cognitively intact, required physical assistance with bed mobility, toileting and personal hygiene and was always incontinent of bowel and bladder. On 10/2/20, at 10:26 a.m. during observation of R4's incontinence cares there was a knock on the door, and without waiting housekeeper (H-A) entered R4's room without waiting and put boxes of gloves on the shelf across from R4's bed and said, "Just giving you gloves, we have no small	21805	corrected	11/20/20

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	00913	A. BUILDING: ______ B. WING ______	C 10/05/2020

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21805	Continued From page 5	21805		

gloves." NA-A said, "thank you." R4 was lying on left side with bare thighs and buttocks exposed. The curtain was not pulled all the way around the bed and this left R4 exposed to anyone who entered.

On 10/2/20, at 10:32 a.m. NA-A verified H-A knocked once and entered before anyone said anything or she was able to cover R4. NA-A stated no one in the room said for H-A to come in. NA-A stated normally people wait to come in, but you are here, and everyone is on edge.

On 10/2/20, at 11:47 a.m. R4 stated staff do not really wait for permission to enter. R4 stated it happens a few times a day. R4 stated she felt bad when it happened, and felt, "exposed." R4 stated, "It is like I have no privacy here." R4 had tears rolling slowly down her face. R4 wiped her face and stated H-A was not a bad person.

On 10/2/20, at 11:58 a.m. H-A stated she thought someone said okay. H-A said, "Plenty of times they say come, when I knock." H-A verified staff were to knock and wait for permission to enter a resident's room.

On 10/2/20, at 2:25 p.m. the director of nursing (DON) stated staff were supposed to pull the curtain around the bed during cares and wait for permission to enter a room.

A policy was requested, but not provided by the facility.

Suggested Method of Correction: The DON (Director of Nursing) or designee could review and/or revise policies, and provide education/ training related to treating residents with dignity

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21805	Continued From page 6 and respect. Then the DON or designee could educate staff and perform audits to ensure the policies are being followed. Time Period for Correction: 21 (twenty-one) days.	21805		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 000	INITIAL COMMENTS On 10/2/20-10/5/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5295195C with a deficiency cited at F557. H5295193C and H5295194C were not substantiated. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F 550		11/20/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 10/29/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide care in a manner that promoted dignity for 1 of 2 residents (R4) observed for privacy during cares.	F 550	The facility adheres to the state and federal regulations and follows the guidance from the Resident Bill of Rights to maintain and enforce compliance in	

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F 550	Continued From page 2 Findings include: R4's quarterly Minimum Data Set (MDS) dated 7/1/20, indicated R4 was cognitively intact, required physical assistance with bed mobility, toileting and personal hygiene and was always incontinent of bowel and bladder. On 10/2/20, at 10:26 a.m. during observation of R4's incontinence cares there was a knock on the door, and without waiting housekeeper (H-A) entered R4's room without waiting and put boxes of gloves on the shelf across from R4's bed and said, "Just giving you gloves, we have no small gloves." NA-A said, "thank you." R4 was lying on left side with bare thighs and buttocks exposed. The curtain was not pulled all the way around the bed and this left R4 exposed to anyone who entered. On 10/2/20, at 10:32 a.m. NA-A verified H-A knocked once and entered before anyone said anything or she was able to cover R4. NA-A stated no one in the room said for H-A to come in. NA-A stated normally people wait to come in, but you are here, and everyone is on edge. On 10/2/20, at 11:47 a.m. R4 stated staff do not really wait for permission to enter. R4 stated it happens a few times a day. R4 stated she felt bad when it happened, and felt, "exposed." R4 stated, "It is like I have no privacy here." R4 had tears rolling slowly down her face. R4 wiped her face and stated H-A was not a bad person. On 10/2/20, at 11:58 a.m. H-A stated she thought someone said okay. H-A said, "Plenty of times they say come, when I knock." H-A verified staff	F 550	respect to resident rights and dignity. Corrective Action as it related to the identified resident (R4): R4 will be reassessed for incontinence and care plan will be reviewed and revised according to the assessment to include interventions for assuring resident privacy during cares. Corrective Action as it applies to others: Like residents will be reassessed for incontinence and care plan will be reviewed and revised as indicated to include interventions for assuring resident privacy during cares. The facility has a policy relating to Resident Rights which remains current. All staff including the housekeeping department, will be re-educated on resident rights to include maintaining privacy during cares and appropriate entry into a resident□s room. Copies of resident rights are posted throughout the facility, and a copy is provided to each employee, provider, and contracted staff member. In addition, staff will have appropriate in-service training on resident rights prior to having direct-care responsibilities for residents. Orientation and Inservice training programs are conducted annually and as needed to assist our employees in understanding resident rights. Inquiries concerning residents□ rights should be referred to the Social Services Director.	

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F 550	Continued From page 3 were to knock and wait for permission to enter a resident's room. On 10/2/20, at 2:25 p.m. the director of nursing (DON) stated staff were supposed to pull the curtain around the bed during cares and wait for permission to enter a room. A policy was requested, but not provided by the facility.	F 550	Recurrence will be prevented by: The clinical educator and/or designee (s) is educating all staff on resident rights relating to knocking on a resident□s room door prior to entering the residents□ room, and to wait for a response of the occupants in the room prior to entering the room. In addition, Staff education will include instructions and direction on providing privacy during incontinence cares, including closing the curtain in the room. Each unit will be audited 5x/week x 4 weeks on residents rights, specifically to observations and interviews with residents and staff to confirm knocking prior to entering a room, waiting for a response, and then entering the room, and pulling curtain during direct hands on cares. The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits. Corrections will be monitored by: Administrator, DON, Social Workers, and/or designee (s). The results of these audits will be shared with the facility QAPI Committee for input on the need to increase, decrease, or discontinue the audits.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		11/20/20

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F 880	Continued From page 4 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 880		

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F 880	Continued From page 5 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate hand hygiene (wash hands with soap and water or alcohol based hand sanitizer use) and glove usage to prevent cross-contamination during cares for 1 of 2 residents (R4) who were observed during personal cares. Findings include: R4's quarterly Minimum Data Set (MDS) dated 7/1/20, indicated R4 was cognitively intact, required physical assistance with bed mobility,	F 880	The facility has a handwashing/hand hygiene policy and procedure that is in according with CDC and MDH guidance. Corrective Action as it related to the identified resident (R4): R4 will be reassessed for incontinence and care plan will be reviewed and revised to include interventions for maintaining standard infection control precautions during incontinence care.	

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F 880	Continued From page 6 toileting and personal hygiene and was always incontinent of bowel and bladder. On 10/2/20, at 10:19 a.m., nursing assistant (NA)-A entered R4's room and opened the top drawer of R4's bedside table and pulled out a package of wipes and closed the drawer. NA-A put gloves on without performing hand hygiene. NA-A pulled R4's pants down and opened the brief tabs. NA-A used wipes and washed R4's perineal area. NA-A had R4 roll to the left using the grab bar. R4's incontinence brief was full of soft brown stool. NA-A wiped the stool off R4's buttocks and removed the brief. Without changing gloves, NA-A picked up a clean brief and placed it on the bed. Wearing the same gloves, opened the top drawer to the bed side table and removed a tube of barrier cream from the bed side table. Using the same gloves, used to clean stool from R4's buttocks, NA-A applied barrier cream to R4's buttocks then had R4 roll onto the clean brief and applied the barrier cream to her perineal area. NA-A had R4 roll back onto the clean brief. Without changing gloves, NA-A pulled up R4's pants, pulled down shirt and then removed gloves. Without performing hand hygiene NA-A touched and returned the wipes and barrier cream into the drawers of the bedside table. NA-A took the bag of trash out of the can and exited the room. NA-A opened the door to the soiled utility room and threw the trash away, then washed her hands. NA-A stated this was how she normally did R4's cares. NA-A stated she had used sanitizer before entering R4's room. NA-A verified she did not change gloves when done wiping the stool from R4's bottom until after adjusting R4's clothes. NA-A verified not sanitizing hands until washing them in the soiled utility room.	F 880	R4 ADL care plan will be reviewed and updated to reflect current ADL needs, and interventions for maintaining standard infection control precautions and hand hygiene during incontinence care. Corrective Action as it applies to others: The facility has a handwashing/hand hygiene policy and procedure that is in according with CDC and MDH guidance. The facility has policies and practices for Infection Control to facilitate maintaining a safe, sanitary, and comfortable environment and to help and manage transmission of diseases and infections. All personnel are trained on infection control practices upon hire, and periodically thereafter. The depth of the training shall be appropriate to the degree of direct resident contact and job responsibilities. All other like Residents plan of care will be reviewed and updated to reflect current ADL needs, and interventions for maintaining standard infection control precautions and hand hygiene during incontinence care. All other like residents will continue to be provided incontinence care as outlined in their individual/comprehensive care plan and assessment and while maintaining standard infection control precautions and completing proper hand hygiene and glove usage during incontinence care. Recurrence will be prevented by:	

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F 880	Continued From page 7 On 10/2/20, at 2:25 p.m. the director of nursing (DON) stated gloves were to be changed between dirty and clean tasks and hand hygiene was to be done prior to putting on or removing gloves, and after cares. The DON stated staff should have changed gloves after doing incontinence cares before adjusting clothing or reaching into a resident's dresser drawer. Facility provided Hand washing/Hand Hygiene Policy revised August 2019, indicated facility considered hand hygiene the primary means to prevent the spread of infections. The policy indicated hand hygiene was to be performed before donning and removing gloves and before moving from a contaminated body site to a clean body site during cares.	F 880	All staff who perform direct care services will be educated on hand hygiene and glove usage to prevent cross-contamination during cares. The hand hygiene education clearly directs expectations in which employees must perform hand hygiene and glove changes after going from a dirty to clean task. Staff education initiated regarding reviewing, following, and providing incontinence care based on the resident□s plan of care, and interventions for maintaining standard infection control precautions and proper hand hygiene and glove usage during incontinence care. The infection preventionist and/or designee (s) will be conducting visual audits 5x/week x 4 weeks on direct care audits in which cross-contamination could occur. Visual audits will be completed to ensure incontinence care is being provided according to facility hand hygiene and glove usage infection control standards, policies, and procedures, and privacy is being adequately provided during care. Corrections will be monitored by: The Administrator, DON, and/or designee (s). The results of these audits will be shared with the facility QAPI committee for input on the need to increase, decrease, or discontinue the audits.	